Medical Care Advisory Committee

Minutes of January 19, 2017

Participants

Committee Members Present

Andrew Riggle (Chair), Dr. William Cosgrove (Vice-Chair), Mark Brasher, Kevin Burt, Steven Mickelson, Mark Ward, Dr. Samuel Bailey, Danny Harris, Doug Springmeyer, Christine Evans, Jessie Mandle, Nate Checketts, Debra Mair (via phone) Jenifer Lloyd (via phone), Sara Carbajal-Salisbury (via phone)

Committee Members Excused

Jonathan George, Ginger Phillips

Committee Members Absent

Adam Cohen, Donna Singer, Pete Ziegler

Guests

Micah Vorwaller-UHPP, Joyce Delcourt-LCPD, Amy-Rose White-Utah Maternal Mental Health Collaborative, Kris Fawson,-USILC, Kim Michelson-DDS, DOH Oral Health Program, Chad Westover-U of U Health Plans, Melissa Zito-UDOH, Dr. Charles Pruitt.

Welcome

Andrew Riggle called the meeting to order at 1:30 p.m. and announced the two new MCAC members to the committee. Dr. Samuel Baily, Pediatric Dentistry and Ginger Phillips, Mental Health Community. Dr. Bailey introduced himself. Ginger Phillips was not able to attend.

Approval of Minutes

Doug Springmeyer made the motion to approve the November 1, 2016 minutes. Mark Brasher seconded the motion. All were in favor. None opposed.

New Rulemakings CRAIG DEVASHRAYEE

A handout on the six new rulemakings with filing for public comment and effective dates were reported by Craig.

- R380-400 Use of Statistical Sampling and Extrapolation (Rule Repeal)
- R382-10-11 Household Composition and Income Provisions
- R414-304-5 MAGI-Based Coverage Groups
- R414-504 Nursing Facility Payment
- R414-302-6 Residents of Institutions
- R414-1-5 Incorporations by Reference
- R414-10A Transplant Services Standards (Five-Year Review)
- R414-21 Physical Therapy and Occupational Therapy (Five-Year Review)

Jessie Mandle requested clarification of new rule R382-10-11 and R414-304-5 regarding spouses separated but filing a joint tax return, and how this affects families. Jeff Nelson reported this is a clarification to CMS regarding how UDOH treats these households in regards to eligibility. He further explained if an estranged spouse plans to file jointly and lives in a separate residence, DWS looks at each household individually. Some states prefer looking at the household

together. Steve Mickelson asked for clarification on how these households are treated with regards to income. Jeff Nelson explained further.

Eligibility Update — JEFF NELSON

Jeff distributed a handout on the Medicaid, CHIP, and PCN totals. Jeff reported PCN showed a decline due to the current closed enrollments. Jeff noted a decline in pregnant woman enrollment, but stated these are married pregnant women, which he stated would make sense in households with two incomes. Nate clarified only PCN enrollment for adults without dependent children is closed, and enrollment for parents with dependent children is still open.

Andrew questioned the high increase in December for people with disabilities under 65 and wondered if this was consistent in prior years or if there was a trend. Jeff reasoned the increase shown might be that November's numbers might have been pulled before reviews were completed, and the numbers were added to the December's numbers making this high. Jeff stated that the Medical Review Board has for the past several years reviewed 450-500 cases, and now it's gone up to 550-600 cases due to more approved applications.

Danny Harris requested if a trend data chart could show the Medicaid categories of eligibility from month to month. Jeff stated the data is available, but not included on the report. Committee discussed that this was recently changed, and it was suggested to add the data monthly for a 3-year period. It was suggested possibly reviewing this data quarterly. Nate stated because the data is available monthly, it makes sense to just provide it monthly. UDOH will look at adding this data. There was a discussion regarding the validity of the data based on when it is pulled in a month and how often. Kevin Burt stated he can work with Jeff to determine which data to use. Nate then stated that UDOH has the data needed and would want to use the same source already being used for the current report.

Doug Springmeyer asked a question on the high enrollment breakdown for children. Doug remarked on a report from the Tribune newspaper indicating Utah had the lowest rate of insured Hispanic children, and highest rate of uninsured Hispanic children. He asked if this data indicates ethnic diversity in the number of kids that we are losing, opposed to other categories, and is there data available. Jeff replied this does not reflect that type of data in the report, but the data can be retrieved. Kevin Burt spoke and reported the category of race or ethnicity on eligibility applications is not required. It's self-attestation and is not verified. He stated the majority of people do not report this information. Jeff stated that for those that do report, the data can be pulled.

Jessie Mandle reported she noticed on the 2016 Medicaid Annual Report there was a category for race, but not a category by ethnicity. Jessie suggested this might be of interest not only for her but for others, to see a trend line by ethnicity reported annually.

Doug asked if the consensus in the fall was modeled on certain enrollments and if this followed the trends, and are there any major changes that were predicted. Nate stated the general projections followed trends. Nate reported consensus numbers last February did not decline and projected a slight growth. This will be taken into account in February's review of current consensus process.

Maternal Depression Screening and Treatment — Amy-Rose White

Amy-Rose White, LCSW, director and founder of the Utah Maternal Mental Health Collaborative (UMMHC) presented. It was reported the collaborative's goal is to increase and improve awareness, prevention, detection, and treatment of

maternal mental health conditions in Utah. The goal is that every woman in Utah receives information on risk, prevention, and treatment of pregnancy and postpartum mood and anxiety disorders.

Amy-Rose stated her main goal today is to provide a basic overview on the topic, but also to plead the case as to the importance of why women need and deserve Medicaid coverage beyond the first 60 days after birth. She presented a PowerPoint presentation on the recognition of maternal anxiety and depression, cause of maternal depression, characteristics of maternal depression, accessing treatment, and the impact of depression during pregnancy. Discussion regarding screening, treatment and coverage was a concern. Amy provided the following statistics:

- Suicide is the second leading cause of death in the first year postpartum
- 80% of women suffer from baby blues. Depression is different.
- If the feelings experienced persists beyond 2 weeks, it is likely PPD or a related disorder
- 14-25% of women suffer from perinatal depression
- Postpartum depression (PPD) and anxiety usually starts 1-3 months postpartum, but can occur anytime in the first year after birth
- At least 60% start in the first 6 weeks
- Medicaid covers around 31% of Utah births
- Given the percentage of women with PPD this equals around 2000 Medicaid moms with PPD
- Women on Medicaid have higher rates of PPD than the average
- Negative impacts of untreated maternal depression are many

Doug Springmeyer asked if the fact that medical and mental health systems are separate have any impact. Amy responded that they absolutely have an impact. Women generally turn to their OB/GYN for help, which may not deal with this issue as frequently. The collaborative helps provide information to providers with this issue. It is important that providers work together in identifying and treating women with these issues.

Steve Mickelson asked Amy what her suggestion would be regarding the length of coverage for women after giving birth, given that women on Medicaid only receive coverage for 60 days after. Amy stated the first year should be covered.

Jessie asked if pediatricians can screen for depression. Dr. Cosgrove responded that pediatricians are being pushed to screen for depression by the American Academy of Pediatrics. Some are doing it and some aren't. But pediatricians then have to refer them back to their OB/GYN and they have missed the 6-week period. He also stated it is hard to ask the screening questions of someone that isn't their patient, and about a subject they really aren't trained in.

Amy stated there is a tool kit for doctors to screen, but it is hard to fit it into everything else that is being covered during a well-child check.

Dr. Cosgrove added that children can be permanently affected by a mother suffering maternal depression. Their early childhood is not optimized and is harmed by the community not paying attention to their mother's depression.

Andrew asked if the collaborative is working with Rep. Redd on his bill to cover mothers for one year after birth for mental health services. Amy stated they have not worked with him yet, but they have started working with other groups and hoping to get a meeting with him.

Nate Checketts spoke tying this discussion with Medicaid eligibility. Nate Checketts reported coverage for pregnant women and children are at a different level than other groups. Nate reported pregnant women, with the Affordable Care Act (ACA), provides coverage up to 139% plus 5% FPL disregard taking it up to 144% of poverty. The child will have coverage for a year after birth, and if eligible will continue on a child program with Medicaid. The mother has options

depending on their income level, or could be on an exchange program. Another coverage option is if the mother is under the 30% FPL she could be on the parent program after the 60 day coverage. Last option would be the PCN program which is open on a continual basis, but it does not cover mental health issues.

More information can be found at Utah Maternal Mental Health Collaborative website www.utahmmhc.com.

Medicaid Services Received through IHS/Tribal Facilities — Tonya Hales

Tonya Hales, Assistant Director for Medicaid Division and Melissa Zito, MS, RN, AI/AN Health Liaison/Health Policy Consultant, Utah Department of Health presented.

On February 26, 2016, CMS issued a State Health Official letter to inform state Medicaid agencies and other state health officials. This letter provided an update in payment policy affecting federal funding for services received by Medicaid eligible individuals who are American Indian or Alaska Native (AI/AN). Under the updated policy, IHS/Tribal facilities may enter into written care coordination agreements with *non*-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries. Amounts paid by the state Medicaid program for services requested by facility practitioners in accordance with those agreements are eligible for federal matching funds at the enhanced federal matching rate of 100 percent.

Tonya reported prior to the February 2016 letter services for AI/AN received from state Medicaid services were to be provided only by an IHS, tribal facilities or a contracting agent only Medicaid eligible American Indian or Alaska Natives. Tonya noted this was a long standing Medicaid practice until this new provision was set.

Other provisions were reported:

- It is required a care coordination agreement is in place at an IHS provider or non-IHS provider.
- It is required that the IHS or non-IHS both must be enrolled as a Medicaid provider.
- The patient needs to have an established relationship with an IHS facility.
- The IHS tribal facility is responsible for the care of the client whether they receive services at the IHS or at a non-IHS facility. All documentation and medical records held at a non-IHS facility will be provided to the IHS tribal facility.
- If referred to an IHS facility or non-IHS facility and the AI/AN have a care coordination plan in place they have an option to self-refer if they choose to not receive services that were referred to them.
- Services provided can be billed by a non-IHS facility to the state Medicaid program.
- States can claim 100% federal match who are enrolled in a managed care plan.

Dr. Cosgrove questioned the eligibility of a Native American family with a spouse or children who might not meet the criteria of tribal enrollment.

Melissa Zito reported to be eligible to receive services through an IHS or tribal facility for the 100% funding, the individual does need to be a member of a recognized tribe. If you have a non-Indian child or family member that is not recognized or enrolled in a tribe they are not able to receive services. Tribal facilities might possibly make an exception, but IHS facilities would not.

HEDIS/CAHPS Measure — Julie Ewing

Julie reported on the 2016 HEDIS and CAHPS measures. She stated the goal is to be at, or above the national average for all measures. Presented was an overall summary of managed care plans (Accountable Care Organization or ACOs).

Julie reported measures were selected through a series of public meetings with input from the ACOs and other stakeholders, as well as advice of the division of Medicaid and Health Financing director and the Medicaid medical

director. ACO's were contracted to focus on a small set of measures to be performing at, or above the national average by the year 2019. Julie indicated ACO's are required to submit a Quality Targeted Improvement Plan (QTIP) with explanation of how they have maintained the national average, and how they will keep that average, as well as a reasons it has not kept up the national average. Julie stated the measures that are presented today are the measures that are in the contracts with the ACOs in which they are required to submit via a QTIP.

A HEDIS and CAHPS measures data report titled *2016 Quality Update-Utah Medicaid ACO Quality Measures* was distributed for review. Julie focused on the state average data, highlighting the successes and areas that needed improvement. Julie stated those that needed improvement will be followed up with the ACOs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to develop surveys of patients' experiences with the healthcare they receive from health plans, providers, and facilities such as hospitals, in-center hemodialysis facilities, and home health agencies. Surveys measure perceptions of care and are conducted on the adult population in odd numbered years, and on the child population in even-numbered years. The CAHPS surveys for 2016 was a pediatric survey.

Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA) health plans to measure performance on important dimensions of care and services. HEDIS makes it possible to compare the performance of health plans.

Andrew asked if there are incentives for those that meet or exceed the national average. Julie reported incentives have been considered but currently not in place.

Danny Harris asked how the ACO average is calculated. Julie Olsen, Quality Program Manager, replied it's a simple average of the rates.

Dr. Cosgrove requested that a comparison of patient satisfaction with Medicaid ACO plans verses the commercial rates data be sent out to the group. Julie Olsen replied she can provide this data.

Jessie asked when the contracting period will take place. Julie replied ACO's contracts started in 2013 with a 5 year contract. She asked if there is opportunity for additional measures to be included. Julie replied, in light of the managed care regulations, there is a timeline for managed care quality strategy and input from public stakeholders will be requested.

Doug Springmeyer asked what the plans are after the ACOs contract ends and will there be any changes. Julie replied there will be no changes. Emma stated with managed care regulations there will be amendments to the contracts.

Combining MCAC and CHIP Advisory Meetings — Jeff Nelson

Jeff presented a proposal to combine the MCAC and CHIP advisory meetings. The proposal is to better utilize meeting schedules and dates by unifying both advisory groups together. Jeff reported CHIP meets quarterly to discuss children health programs and issues. He indicated the information relayed at the CHIP meeting is redundant as they are also discussed at the MCAC meeting. The first proposal is scheduling the CHIP meeting right after the MCAC meeting. The second proposal is to have CHIP meet quarterly with the MCAC committee to discuss not only children issues, but other pertinent issues as well. Jeff mentioned the state statute for CHIP is to meet as a board and to meet quarterly. It was asked if this could be changed in the statute to combine the two advisory committees. Jeff asked for comments and recommendation from MCAC members.

Jesse commented that she doesn't have any concerns with combining, but there could be many changes coming with the new federal administration.

Danny Harris stated his concerns of combining MCAC and CHIP due to the variety of topics of Medicaid beyond child health issues. Danny also stated there could be a concern for someone who is a child health advocate and might want special attention for children's issues.

Andrew commented that once a quarter combined meeting might be helpful for the MCAC group to have a better understanding of a program we need to interact with, but don't have a good understanding of how it functions. It would not be an additional burden on the MCAC.

Danny asked if the committee is okay to wait until the next year for statutory changes if we decide to combine the meetings. Nate stated we could avoid this by having people that are appointed to both committees. The committees could meet on the same day after one had met.

MOTION: Mark Brasher made a motion to set this as an agenda item in March to make a recommendation after receiving more information. Doug Springmeyer seconded. All in favor. None opposed.

Director's Report

Nate Checketts

Governor's Budget Recommendations

- Opioid misuse/abuse was funded at $250,000 one-time funds, covering naloxone funding and education.
- Baby watch early intervention funded at $2.7 million total, including one-time and on-going funding.
- Consensus process-$9.7 million "give-back" due to receiving more funds in our budget than was needed. Our estimates of our cost per member were less than what was projected.
- Senate Bill 39- *Medicaid Coverage for Adult Dental Services* passed last year but was not fully funded. Nate reported the Governor's budget proposes the necessary ongoing funds for that program.
- The Governor added on-going funds of $429,600 for parents and other well-adult preventive visits which prior was not covered.
- Family planning services was funded $570,000 on-going money to cover individuals that are not eligible for other coverage.
- As part of House Bill 437 the legislative fiscal analysts removed the budget for PCN slots to create savings. This was not supported by the Governor. The Governor's budget restores PCN slots with $1.2 million dollars with on-going funds to maintain the current PCNS slots.
- There was a 2% increase for ACOs for inflation with the Governor adding .6% more, proposing an increase of 2.6% for ACOs.

Medicaid Cost Expansion Report

Nate distributed a report on amounts for 2015 APTC payments to Utah issuers which is based on the CMS December 2015 payment cycle. The total additional 2015 benefit year CSR payment that CMS has made to date as a result of the CSR reconciliation process was also listed.

Nate reported that individuals in Utah received $196 million in advanced premium tax credits (APTC's) for 2015. There was an additional $51.4 million issued to help those individuals with the lowest incomes to reduce co-pays and deductibles. This brings the total to $247 million that the federal government paid to individuals for cost sharing deduction.

Danny Harris asked what the previous estimates were for no expansion prior to the data being received. Nate reported the legislative fiscal analyst (LFA) number for APTC's was $430 million and the number for cost sharing was $620 million, a combined total of $1.05 billion. Nate stated the fiscal analyst is the best person to speak to these numbers.

Jessie requested an update on House Bill 437. Nate reported early December there was a discussion with the federal government regarding the waiver approval to cover adults without dependent children. They stated the current administration would not be taking action on the waiver. CMS did indicate it was willing to approve the portion of HB 437 that increased the income limit to 55% FPL for parents. UDOH is waiting for Governor and legislative leadership approval to move ahead with this.

Nate reported a preferred drug list for psychotropics was implemented on July 1, 2016. This was not contingent on the waiver approval, so the department intends to continue this. The hospital tax is contingent on waiver approval, so this will not happen until/if the waiver is approved.

Nate provided an update on the 1115 Waiver amendment for dental benefits for adults with disabilities or blindness. Nate reported Senate Bill 39 did not fund this program, and UDOH is waiting to see if there will be legislative funding. DOH is moving forward on the 1115 amendment to ensure everything is in place by May 1, 2017. Submitting the waiver amendment as early as tomorrow.

Andrew spoke and asked for any suggested agenda items from MCAC committee members. These items are to be submitted to Jennifer Meyer-Smart.

Next MCAC meeting will be an informal meeting at the State Capitol in the Olmsted Room, Thursday, February 16, 2017, 1:30 p.m. to 3:30 p.m.

Andrew made the motion to adjourn meeting at 3:45 p.m. Motion was seconded. All were in favor. None opposed.